

FILTER CIGARETTE REPORT FORM

PART A

To Be Filled Out After You Have Smoked All Of The Philip Morris Ultra Lights Cigarettes, Or At The End Of 5 Days.

Now that you have tried The Philip Morris Ultra Lights Cigarettes, we would like you to tell us how you think they compare with other cigarettes you have tried. For each of the following, simply check the box that comes closest to describing how you feel about them.

<u>TASTE</u>	<input type="checkbox"/> Very Strong Taste	<input type="checkbox"/> Strong Taste	<input type="checkbox"/> Average Taste	<input type="checkbox"/> Mild Taste	<input type="checkbox"/> Very Mild Taste
<u>HOW DID THE CIGARETTES DRAW?</u>	<input type="checkbox"/> Very Hard To Draw	<input type="checkbox"/> Hard To Draw	<input type="checkbox"/> About Average	<input type="checkbox"/> Easy Draw	<input type="checkbox"/> Very Easy Draw
<u>HARSH OR SMOOTH TO MOUTH OR THROAT</u>	<input type="checkbox"/> Very Harsh	<input type="checkbox"/> Harsh	<input type="checkbox"/> Neither Harsh nor Smooth	<input type="checkbox"/> Smooth	<input type="checkbox"/> Very Smooth
<u>OVERALL...HOW DID YOU LIKE THEM?</u>	<input type="checkbox"/> Like Them Very Much	<input type="checkbox"/> Like Them Fairly Well	<input type="checkbox"/> It's Just OK	<input type="checkbox"/> Don't Like Them Very Much	<input type="checkbox"/> Don't Like Them At All

WHAT DID YOU DISLIKE ABOUT THEM? _____

WHAT DID YOU LIKE ABOUT THEM? _____

PART B

To Be Filled Out After You Have Smoked All Of The Summit Ultra Lights Cigarettes, Or At The End Of 5 Days.

Now that you have tried The Summit Ultra Lights Cigarettes, we would like you to tell us how you think they compare with other cigarettes you have tried. For each of the following, simply check the box that comes closest to describing how you feel about them.

<u>TASTE</u>	<input type="checkbox"/> Very Strong Taste	<input type="checkbox"/> Strong Taste	<input type="checkbox"/> Average Taste	<input type="checkbox"/> Mild Taste	<input type="checkbox"/> Very Mild Taste
<u>HOW DID THE CIGARETTES DRAW?</u>	<input type="checkbox"/> Very Hard To Draw	<input type="checkbox"/> Hard To Draw	<input type="checkbox"/> About Average	<input type="checkbox"/> Easy Draw	<input type="checkbox"/> Very Easy Draw
<u>HARSH OR SMOOTH TO MOUTH OR THROAT</u>	<input type="checkbox"/> Very Harsh	<input type="checkbox"/> Harsh	<input type="checkbox"/> Neither Harsh Nor Smooth	<input type="checkbox"/> Smooth	<input type="checkbox"/> Very Smooth
<u>OVERALL...HOW DID YOU LIKE THEM?</u>	<input type="checkbox"/> Like Them Very Much	<input type="checkbox"/> Like Them Fairly Well	<input type="checkbox"/> It's Just OK	<input type="checkbox"/> Don't Like Them Very Much	<input type="checkbox"/> Don't Like Them At All

WHAT DID YOU DISLIKE ABOUT THEM? _____

WHAT DID YOU LIKE ABOUT THEM? _____

IMPORTANT: PLEASE KEEP THIS REPORT FORM HANDY UNTIL WE TELEPHONE YOU. DO NOT RETURN IT TO US.

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